ISAACS/JELLINEK
847 25TH AVENUE
SAN FRANCISCO, CA 94121

STATE HEALTH REFORM INITIATIVES: A COMPARATIVE REVIEW

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State Health Reform Initiatives: A Comparative Review

States have taken a number of approaches to increasing health insurance coverage for their residents. Massachusetts took the lead in 2006 with its plan for comprehensive reform that required individuals to have health insurance, penalized businesses that did not provide insurance for their employees, subsidized premiums for low-income individuals, and set up a mechanism to connect purchasers and sellers of health insurance. Three years earlier, Maine had passed Dirigo Health, a voluntary plan; it has not attracted the number of enrollees anticipated and is being re-structured. Vermont passed its Catamount Health Plan shortly after Massachusetts enacted its plan. In addition to expanding health insurance and subsidizing the cost for low-income individuals and families, Vermont's plan encourages chronic care management, which is thought to improve quality and lower costs. These three plans are described on pp. 2-6.

The Massachusetts plan—the product of a Republican governor (Mitt Romney) and a Democratically controlled legislature—triggered reform efforts in other states aimed at covering all residents. We discuss briefly the plans proposed by the governors of California, Illinois, and Wisconsin on pp. 7-8.

Other states have passed or proposed laws that expand coverage but do not attempt to cover the entire state's population. Among them are Arkansas, Colorado, Delaware, Kentucky, Montana, New Mexico, New York, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, and Washington. They take differing approaches: raising eligibility limits for children's coverage; developing new health insurance products; establishing purchasing pools to obtain greater bargaining leverage; and subsidizing coverage for small businesses and individuals. A Maryland law mandating that large employers spend 8 percent of their payroll on employee health insurance, which applied only to Wal-Mart, was struck down in January 2007 as violating ERISA. Five plans—Montana, Oklahoma, New York, Washington, and Illinois—are discussed briefly on pp. 9-10.

States have shown considerable variety in financing their expansion of health insurance. Among the approaches are raising tobacco taxes; assessing employers who do not provide insurance for their workers; accessing federal matching funds through Medicaid waivers (especially Health Insurance Flexibility and Accountability—HIFA—waivers); tapping pools of money set aside for charity and uncompensated care; receiving new income from premiums; and raising taxes. States are also looking to cut costs by encouraging preventive care, promoting managed care, grouping small groups into larger ones; combining risk pools; reducing the number of required mandates; and placing a greater financial responsibility on insured individuals.

State Plans Aimed at Covering All or Substantially All Residents

Massachusetts

In April 2006, Massachusetts passed health reform legislation designed to cover 95 percent of the state's residents by 2009. A compromise between Republican governor Mitt Romney and a legislature controlled by Democrats, Commonwealth Care incorporates expansion of public insurance programs favored by the left and reliance on private insurance favored by the right. The plan is being implemented in three stages between October 2006 and July 2007.

Key Components

- **Individual health insurance mandate**. All adults in the state must have health insurance, if affordable coverage is available.[1]
- **Employer requirements.** Employers with 11 or more employees that do not provide or make a "fair and reasonable"[2] contribution to their employees' health insurance premiums will be assessed an annual charge of $295 per employee.[3] Employers must offer section 125 "cafeteria plans"—plans that enable employees to buy health insurance with pre-tax dollars—even if their employer does not contribute to their insurance coverage. Employers that don't offer to contribute to or arrange for the purchase of health insurance can be assessed a "free rider" surcharge.
- **Purchasing arrangement—The Commonwealth Health Insurance Connector.** To make it easier for individuals and small companies to obtain health insurance, the law established the Connector, a new statewide authority that serves as a clearinghouse to facilitate the buying, selling, and administration of health insurance policies. The Connector:

    1. Connects individuals and businesses with 50 or fewer employees with affordable (as defined by the Connector) insurance products.[4] Policies cannot be sold through the Connector without receiving its prior approval. Plans marketing their products through the Connector will be able to develop new benefit packages designed to make coverage more affordable.
    2. Facilitates the process of small employers offering section 125 cafeteria plans.[5]
    3. Administers the Commonwealth Care Health Insurance Plan, which provides subsidized insurance coverage to low-income people (see below). In this regard, it serves as a third-party administrator.
- **Premium subsidies for low-income individuals and families.** The Commonwealth Care Health Insurance Program provides sliding-scale subsidies to individuals with incomes up to

[1] The definition of "affordable" was left to the Connector. The penalty for noncompliance will be 50 percent of what a person would have paid for an affordable insurance policy.
[2] The test is met if at least 25 percent of full-time employees are enrolled in the company's group health plan and the employer contributes toward the premium, or if the employer can demonstrate that it offered to pay at least 33 percent of their full-time employees' health insurance premium.
[3] Governor Romney vetoed this provision, and the Legislature overrode his veto.
[4] Part-time and seasonal employees can combine their employer contributions in the Connector. The Connector also allows individuals to keep their policy if they change jobs.
[5] The option of employees purchasing coverage themselves via a section 125 plan may serve as a disincentive for employers to cover their employees independently. It will depend on the particular plan offerings available in the Connector.

300 percent of the federal poverty level for the purchase of health insurance. Individuals with incomes less than 100 percent of the federal poverty level pay no premium.[6]

- **Medicaid expansion.** The law increases eligibility for MassHealth, the state's Medicaid program, to include children of families who earn up to 300 percent of the federal poverty level. It also increases payment rates to Medicaid providers.
- **New insurance products**. In July 2007, the small-group and individual insurance markets will be merged.[7] Through the Connector, new insurance products will be encouraged, including ones specifically designed for people between 19 and 26.

Financing

In addition to the income from individual and employer contributions it will receive, the state is redirecting $385 million in federal Medicaid funds that had been used previously to fund safety net services and uncompensated care. The money will now be used to cover health insurance subsidies. In addition, Massachusetts plans to allocate $300 million from general revenues. The plan is expected to cost $1.2 billion over three years.

Issues and Concerns

- Many difficult-to-resolve operational issues were left to the Connector. These include determining what constitutes an "affordable" health plan. (The individual mandate kicks in only when affordable health plans are in place.)
- Is the plan adequately funded? This is not wholly clear. Legislators indicated that low-cost products should cost $200-250/month. The average cost of a premium for a single adult nationwide was $335 in 2005. In March 2007, the Connector approved plans from seven insurers with premiums ranging from $175 to $288 a month and deductibles ranging from zero to $2,000 a year. The Connector also allowed participating health plans to set lifetime caps and required them to provide prescription drug coverage.
- Will the plan be sustainable in an economic downturn? In a recession, it is not clear whether individuals will be able to pay for premiums, whether businesses will be able to cover the cost of their mandate, and whether the state will be able to fund subsidized policies with decent benefits.
- Will the plan contain health care costs? Rising health care costs could trump the coverage goals and swamp the plan's financing, particularly in a sluggish economy. The law addresses cost containment only marginally by setting up a Health Care Quality and Cost Council. It is not clear whether the Connector will have sufficient bargaining power to keep premiums at attractive levels.

[6] The plans offered through the program have no deductibles and will be offered by managed care organizations that participate in the state's Medicaid program.

[7] It is estimated that this will reduce the cost of non-group premiums by 25 percent.

Vermont

In May 2006, a Democratically controlled legislature and Republican governor Jim Douglas agreed upon the Health Care Affordability Act. To reach its goal of providing insurance coverage to 96 percent of Vermonters and controlling rising health care costs, the law establishes a health insurance plan, Catamount Health, for uninsured Vermonters; subsidizes premium payments and asseses a charge to businesses that don't insure their workers; and encourages chronic disease management. The plan becomes operational in October 2007. A legislative committee will evaluate it in 2009.

Key Components

- **Catamount Health** is a health insurance plan for Vermonters who have been uninsured for twelve months. The plan, which will be offered by Blue Cross Blue Shield and MVP Health, provides a comprehensive package of services, including primary care and chronic care management.[1] It subsidizes, on a sliding scale, care for individuals and families with incomes up to 300 percent of the federal poverty level, and for people enrolled in employer-sponsored plans with incomes 150-300% of the federal poverty level.
- **Chronic Care**. Noting that 75 percent of health spending today is for people with chronic conditions, the plan aligns itself with the state's *Blueprint for Health*, which encourages use of the "chronic care model."[2] It waives deductibles and co-payments for primary care and chronic care maintenance in Catamount Health, and requires that the chronic care model be built into the state's Medicaid and other subsidized insurance programs. *All* Vermonters are eligible to receive free immunizations and a Healthy Lifestyles health insurance discount.

Financing

The state will levy an annual assessment of $365 per full-time equivalent worker on employers without a plan that covers some part of the cost of their employees' health care.[3] Most of the money for Catamount Health is expected to come from an increase in the state's tobacco tax, enrollee premiums, and federal funds released through a Medicaid waiver.

Issues and Concerns

- **Is the plan adequately funded?** The law authorizes the Emergency Board to suspend enrollment if not enough money is available to support premium assistance. In April 2007, the governor's plan to divert money from Catamount Health and use it to fund Blueprint for Health and to pay the insurance companies participating in the plan caused a stir.
- **Will chronic care management save money and improve health?** Among health policy experts throughout the country, there is considerable interest in chronic care management; Medicare and private insurers are encouraging use of the chronic care model through "pay for performance" projects. The benefits of the chronic care model outside of closed managed care systems, however, have not yet been proven.

[1] The law specifies out-of-pocket limits. For example, the maximum for an individual is a $250 deductible and 20 percent co-insurance.
[2] The chronic care model relies on patient education and self-management, a team approach to care, and health information technology.
[3] The law allows employers to exempt eight employees the first two years, six the next year, and so on.

Maine

In 2003, Maine enacted the Dirigo Health Reform Act. Its centerpiece is the Dirigo Health Plan, or DirigoChoice, a strictly voluntary subsidized health insurance plan aimed at small business and low-income individuals. Because enrollment in 2006 was lower than anticipated (19,000 enrollees—60 percent of whom were previously insured—compared with an expected 30,000), Governor John Baldacci proposed major changes in the program, such as requiring individuals to buy health insurance, penalizing employers that don't offer insurance to their workers, and having the state, not a private insurance company, run the program.

Key Components

- **DirigoChoice** is a voluntary program that allows businesses with fewer than 50 employees, part-time employees, and self-employed workers to purchase subsidized health insurance policies. The idea is to pool the enrollees in these three groups into a single group that will then have increased bargaining power. Premiums, deductibles, and co-insurance will be discounted on a sliding scale for enrollees whose household income is less than 300 percent of the federal poverty level. The plan, which is being offered by Anthem Health, provides comprehensive benefits including primary and preventive care. For a business to be eligible, 75 percent of its employees working 20 hours a week or more must enroll, and the company must pay at least 60 percent of the cost of insurance.

- **Medicaid expansion.** Eligibility for the state's Medicaid program was raised from 100 to 150 percent of the federal poverty level for families and from 100 to 200 percent of the federal poverty level for individual adults.

- **Cost containment** is expected to be brought about largely through the acceptance by insurers, hospitals, and practitioners of voluntary 3.5 percent caps on cost and operating margins, plus other cost-control measures.

- **Quality improvement.** The law created the Maine Quality Forum, a quality watchdog group.

Financing. The state planned to pay for Dirigo Health subsidies mainly by levying a 4 percent charge on insurers for the money they save from reduced charity care and bad debt losses. This "savings offset payment" amounted to $30-$40 million the first two years of the program. The insurance industry and the Chamber of Commerce sued over the amount and how it was calculated. They lost in the lower court and have appealed the decision.

Why was enrollment so disappointing? Among the reasons suggested are these:

- The voluntary nature of the program, as evidenced by the poor track record of Dirigo and similar voluntary programs around the nation.
- Premiums increased after the first year because sick people enrolled in DirigoChoice and healthy people did not (adverse selection).
- The savings offset payment mechanism was flawed. It is difficult to calculate savings, and the mechanism angered insurers, whose cooperation was necessary.
- The program required payment of the entire premium upfront and sent a rebate later, which caused people to avoid the program. This policy was later changed.

- Maine is a large, predominantly rural state with many very small businesses and seasonal workers, and has high uninsured rates, only one large insurer, and little available Medicaid (or other federal) money.

Proposed Plans to Cover All or Substantially All State Residents

California

In January 2007, Governor Arnold Schwarzenegger offered a plan to cover substantially all of the state's 6.5 million uninsured residents. Based largely on the Massachusetts plan, the proposal would:

- Require all Californians to have a minimum level of insurance, defined as a policy with a $5,000 deductible and out-of-pocket maximums of $7,500 for individuals or $10,000 for families.
- Require employers with ten or more employees to offer insurance coverage (including the option of letting employees purchase insurance with pre-tax dollars under a section 125 cafeteria plan) or pay 4 percent of their payroll into a state health insurance fund. Employers with fewer than ten employees would be exempt.
- Expand eligibility for the state's SCHIP program to all children (including children in families of undocumented immigrants) whose family income is less than 300 percent of the federal poverty level, and allow Medicaid to cover, at no cost, all legally resident adults with incomes up to 100 percent of the federal poverty level.
- Levy a 2 percent fee on physicians and a 4 percent fee on hospitals, to make up for their increased income coming from the newly insured and increased Medi-Cal rates.
- Set up a purchasing pool through a state agency that will provide a guaranteed source of health insurance for adults.
- Subsidize the purchase of health insurance through sliding-scale subsidies for households with incomes up to 250 percent of the federal poverty level.

The proposal also emphasizes health promotion and disease prevention, and would offer premium reductions and other incentives to individuals who partake in "healthy actions incentives rewards" programs that all insurers and health plans must have. In addition, it promotes the adoption of health information technology throughout the state.

Illinois

Following on the heels of "All Kids," a plan to cover all of the state's uninsured children (it began operation in July 2006), Illinois Governor Rod Blagojevich proposed "Illinois Covered," a plan to provide health insurance coverage for all uninsured residents of Illinois, in March 2007. The plan includes.

- A low-cost health insurance product aimed at small businesses and uninsured individuals.
- A rebate program that subsidizes premium payments in Illinois Covered and employer-provided insurance coverage.
- A program called Illinois Covered Assist for adults below the federal poverty level who do not qualify for Medicaid or employer-sponsored coverage.

Wisconsin

In his state-of-the-state speech in March 2007, Wisconsin Governor Jim Doyle laid out a plan to cover 98 percent of Wisconsin residents. The plan's components include:

- Combining three programs for low-income Wisconsin children and adults (Family Medicaid, BadgerCare, and Healthy Start) into a single comprehensive program, BadgerCarePlus, and expanding eligibility criteria. Funding would come from a variety of sources, including

federal funds (if CMS approves a waiver), greater use of managed care, and savings from more efficient enrollment procedures.

- Creating a purchasing pool to enable small businesses and individuals to buy insurance at affordable rates. To pay for this, the governor proposed increasing the tax on cigarettes, levying a 1 percent assessment on net hospital revenues, and transferring money from the state's malpractice insurance fund.
- Investing in health information technology.

A Sample of Plans Offering Limited Expansion

Subsidizing small businesses and individuals

Montana

In 2006, Montana initiated Insure Montana, a plan to help small businesses offer insurance to their employees through a statewide purchasing pool. It is funded largely by an increased tax on cigarettes. Through the State Health Insurance Purchasing Pool, two options are available for businesses with between two and nine employees, none of whom earn more than $75,000 a year:

- Businesses that already provide health insurance for their employees can apply for a tax credit refund.
- Businesses that do not provide insurance for their employees can apply for coverage through Insure Montana. The state covers half of the employer contribution and between 20 and 90 percent of an employee's contribution, on a sliding scale based on income.

Blue Cross Blue Shield of Montana offers two insurance products under Insure Montana.

Oklahoma

Oklahoma received a Medicaid HIFA waiver in September 2005 that enabled it to launch the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program, which subsidizes health insurance premiums for small businesses and low-income uninsured individuals.

- For small businesses with 50 or fewer employees, O-EPIC covers 60 percent of the health insurance premium for employees (and 85 percent of their spouse's premium) with household incomes up to 185 percent of the federal poverty level. It enables them to enroll in a commercially available plan that meets minimum state standards. Employers are expected to contribute at least 25 percent of the employee's premium. This part of O-EPIC began in November 2005.
- Uninsured individuals not otherwise eligible for coverage earning up to 185 percent of the federal poverty level can apply for the individual plan, which subsidizes insurance premiums on a sliding scale based on income. The individual plan, which commenced in January 2007, provides coverage through private Medicaid managed care plans, though with reduced benefits. To prevent "crowd out," employers cannot have dropped their insurance coverage in the past six months in order to have their employees qualify for the individual plan.

O-EPIC is paid for by means of federal funds made available through the Medicaid waiver and an increase in the tobacco tax (plus individual and employer contributions).

New York

New York State's Healthy New York program was created by the Health Care Reform Act (HCRA) of 2000. It offers discounted insurance policies to eligible small businesses (those with fewer than 50 employees, with at least 30 percent earning $34,000 or less and having been uninsured for the past twelve months), plus sole proprietors, and uninsured working individuals. It provides a streamlined package of benefits, excluding some services otherwise mandated in the state such as mental health, substance abuse, home health care, chiropractic, physical therapy, and hospice. All HMOs are

required to participate. Health plans are reimbursed for 90 percent of claims between $5,000 and $75,000. Funding of Healthy New York comes through a HCRA-funded stop-loss pool.

Expanding coverage of children

Washington

In March 2007, Washington State governor Christine Gregoire signed legislation that will expand health coverage for children under the age of 19 in families earning up to 250 percent of the federal poverty level—regardless of immigration status. Coverage will be free to those earning under 200 percent of the federal poverty level and will be subsidized on a sliding scale for children in families earning between 200 and 250 percent of the federal poverty level. The law calls for a single, streamlined application process in order to remove the barriers caused by three different application procedures.

Illinois

In November 2005, Governor Rod Blagojevich signed the Covering All Kids Health Insurance Act. The law covers any child in the state who has been uninsured for more than a year, with the cost to the family determined on a sliding scale. The program is funded through enrollee premiums, cost sharing and savings from care management, and is partially funded by the federal government for children enrolled in KidCare, the state's SCHIP program.